

REFRACTIVE OPTIONS INFORMED CONSENT FORM

Form Disclaimer

This form has been developed by cataractlens.ca as a free public educational resource to support patient understanding and informed decision-making.

It is intended to reflect general professional standards and practices in Ontario and to help patients better understand their rights, options, and the cataract surgery process.

This form is provided for informational purposes only and may not reflect the specific policies or procedures of your clinic, surgeon, or healthcare provider. Patients are encouraged to review all information carefully and discuss any questions with their eye care professional before making decisions.

Use of this form is voluntary and at the discretion of the patient and provider. Cataractlens.ca assumes no responsibility for its use in clinical or non-clinical settings.

Patient Name: _____

Date of Birth: _____

Health Card Number (optional): _____

Clinic / Surgical Centre: _____

Surgeon: _____

Date: _____

Purpose

This form explains optional refractive services that may be offered in addition to cataract surgery. These services are not medically necessary and are not covered by OHIP.

Understanding of Optional Refractive Services

☐ I understand that cataract surgery is performed to remove the cloudy lens and restore clarity of vision.

☐ I understand that additional refractive services may be offered to improve how clearly I see without glasses after surgery.

☐ I understand that these services are optional and not required to proceed with cataract surgery.

Examples of Optional Refractive Services

These may include, but are not limited to:

☐ Advanced diagnostic testing (to refine measurements and planning)

☐ Laser-assisted cataract surgery (femtosecond laser)

☐ Astigmatism correction procedures (e.g., laser or incisions)

Costs

☐ I understand that these optional services involve additional out-of-pocket costs.

☐ I confirm that I have been informed of these costs in advance and have had the opportunity to ask questions.

Expectations and Limitations

☐ I understand that these services may improve visual outcomes but do not guarantee complete independence from glasses.

☐ I understand that results may vary based on my individual eye condition and healing.

☐ I understand that choosing not to proceed with these services will not affect my access to medically necessary cataract surgery.

Selection

Please indicate your decision:

☐ I choose to proceed with optional refractive services

☐ I decline optional refractive services

If proceeding, specify: _____

Acknowledgment and Consent

By signing below, I confirm that:

- I understand that refractive services are optional and not medically necessary.
- I understand the potential benefits, limitations, and costs.
- I have had the opportunity to ask questions and receive satisfactory answers.
- I understand that outcomes cannot be guaranteed.
- I consent to my selected approach.

Patient Signature: _____

Date: _____

Witness / Staff Name: _____

Signature: _____

Date: _____

Notes (if applicable)